Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

JAMES WEISS MD
3100 TIMMONS LANE SUITE 250
HOUSTON TX 77027

Respondent Name
PENNSYLVANIA MANUFACTURERS IND

Carrier's Austin Representative Box
Box Number 48

MFDR Tracking Number
M4-11-2142-01

MFDR Date Received
FEBRUARY 28, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier refuses to pay this claim for services rendered even after a request for reconsideration was sent."

Amount in Dispute: $1,949.51

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a position summary in the response package.

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 16, 2010	CPT Code 99202	$102.08	$0.00
	CPT Code 95861 (X1)	$183.13	$0.00
	CPT Code 95900 (X6)	$492.66	$0.00
	CPT Code 95903 (X6)	$576.42	$0.00
	CPT Code 95904 (X6)	$433.62	$0.00
	CPT Code 95934 (X2)	$152.54	$0.00
	HCPCS Code A4556	$9.06	$0.00
TOTAL		$1,949.51	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedures for requesting review by an Independent Review Organization (IRO).
4. 28 Texas Administrative Code §130.6 effective January 1, 2007, sets out the requirements for designated doctor examinations for Maximum Medical Improvement and/or Impairment Ratings.
5. 28 Texas Administrative Code §126.7 effective January 1, 2007, sets out the procedures for requesting and general guidelines for designated doctor examinations.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - W1-Workers compensation state fee schedule adjustment.
   - 14-147-Provider contracted/negotiated rate expired or not on file.
   - W9-Unnecessary medical treatment based on peer review.
   - W4-No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. Does a medical necessity issue exist?
2. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.305 and §133.307?
3. Are the disputed services eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for the disputed services based upon not medically necessary.

   The requestor states "As per Rule 130.6 (e) for testing, the Designated Doctor may perform additional testing pr refer the employee to another healthcare provider when deemed necessary to assess an impairment rating. Any additional testing required for the evaluation and rating is NOT SUBJECT TO PRE-AUTHORIZATION requirement in accordance with Labor Code 413.014…THIS CLAIM FOR DIAGNOSTIC TESTING THAT WAS REFERRED BY THE DESIGNATED DOCTOR. PER THE ABOVE RULES AND REGULATIONS-NO PREAUTHORIZATION IS REQUIRED."

   28 Texas Administrative Code §130.6(e) states For testing other than that listed in subsection (d) of this section, the designated doctor may perform additional testing or refer the employee to other health care providers when deemed necessary to assess an impairment rating. Any additional testing required for the evaluation and rating, is not subject to preauthorization requirements in accordance with Labor Code §413.014 (relating to Preauthorization) and additional testing must be completed within ten working days of the designated doctor's physical examination of the employee. Use of another health care provider to perform testing under this subsection can extend the amount of time the designated doctor has to file the report by ten working days."

   28 Texas Administrative Code §126.7(k) states "The designated doctor shall perform additional testing or refer an employee to other health care providers when necessary to determine the issue in question. Any additional testing required for the evaluation is not subject to preauthorization requirements in accordance with the Labor Code §413.014 or Insurance Code, Chapter 1305. Any additional testing must be completed within 10 working days of the designated doctor's physical examination of the employee. The need for additional testing under this subsection extends the amount of time the designated doctor has to file the report by 10 working days."

   The Designated Doctor examination was performed on November 29, 2010. The disputed date of service is December 16, 2010. Because the disputed services were not performed within the timeframe outlined in 28 Texas Administrative Code §133.6(e) and §126.7(k), they are subject to preauthorization requirements. The Division finds that a medical necessity issue exists in this dispute.
2. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury.

28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e)(3)(G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General). The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. Review of the submitted documentation finds that there are unresolved issues of medical necessity for the same service(s) for which there is a medical fee dispute. No documentation was submitted to support that the issue(s) of medical necessity have been resolved prior to the filing of the request for medical fee dispute resolution.

3. The requestor has failed to support that the services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning medical necessity have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 413 prior to the submission of a medical fee dispute request for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is ordered.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	10/09/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.